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Maryland Learning Collaborative

for the Multi-Payer Patient Centered Medical Home Program

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MARYLAND PATIENT CENTERED MEDICAL HOME

HealthyHoward

Howard County Health Department

CRISP

Million Hearts™

JOHNS HOPKINS MEDICINE

NCQA Measuring quality. Improving health care.

MHCC MARYLAND HEALTH CARE COMMISSION

MARYLAND

MCHRC Maryland Community Health Resources Commission

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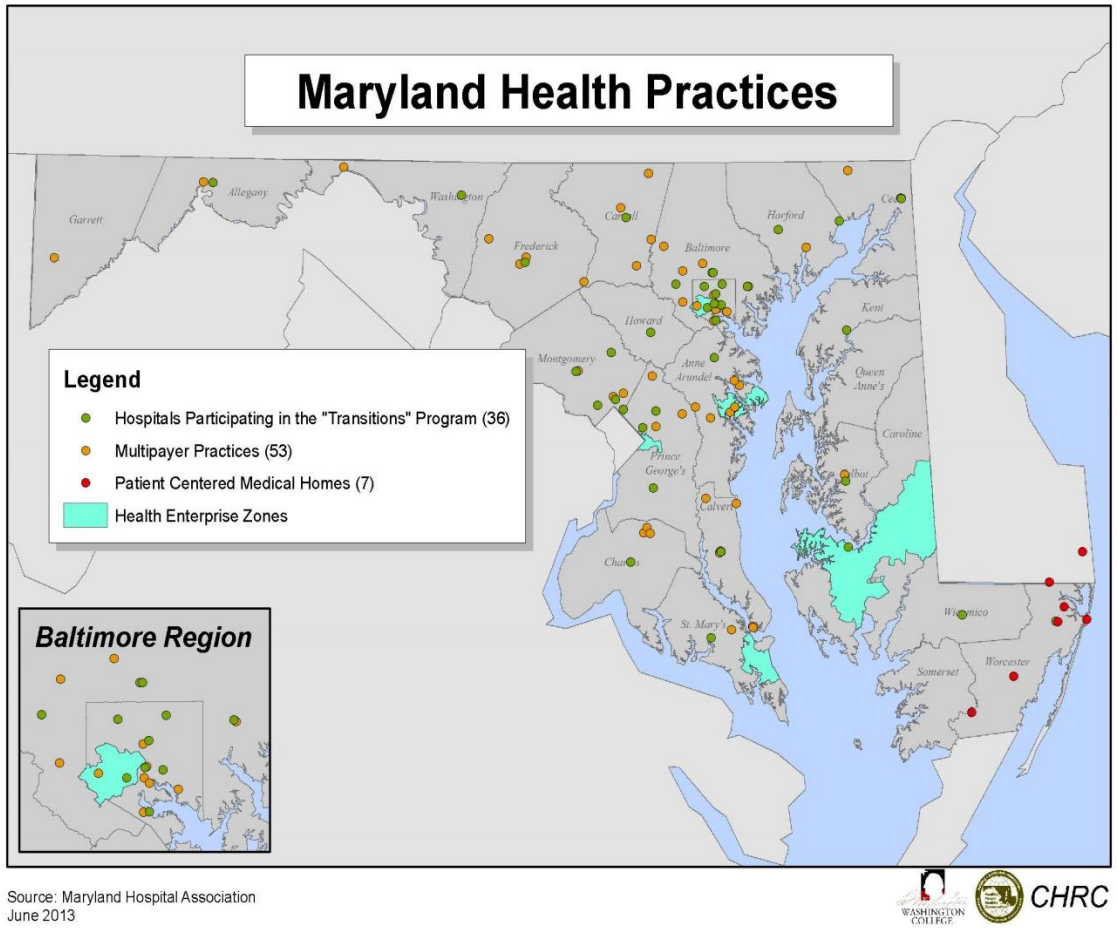
Patient Centered Medical Homes

Reducing readmissions and improving care across settings

IMPROVING CARE:

- Within settings
- Between settings
- Across numerous settings, over time
- Within disciplines
- Among disciplines
- Across clinical and non-clinical boundaries



Maryland Program History

Studies in 2009 showed

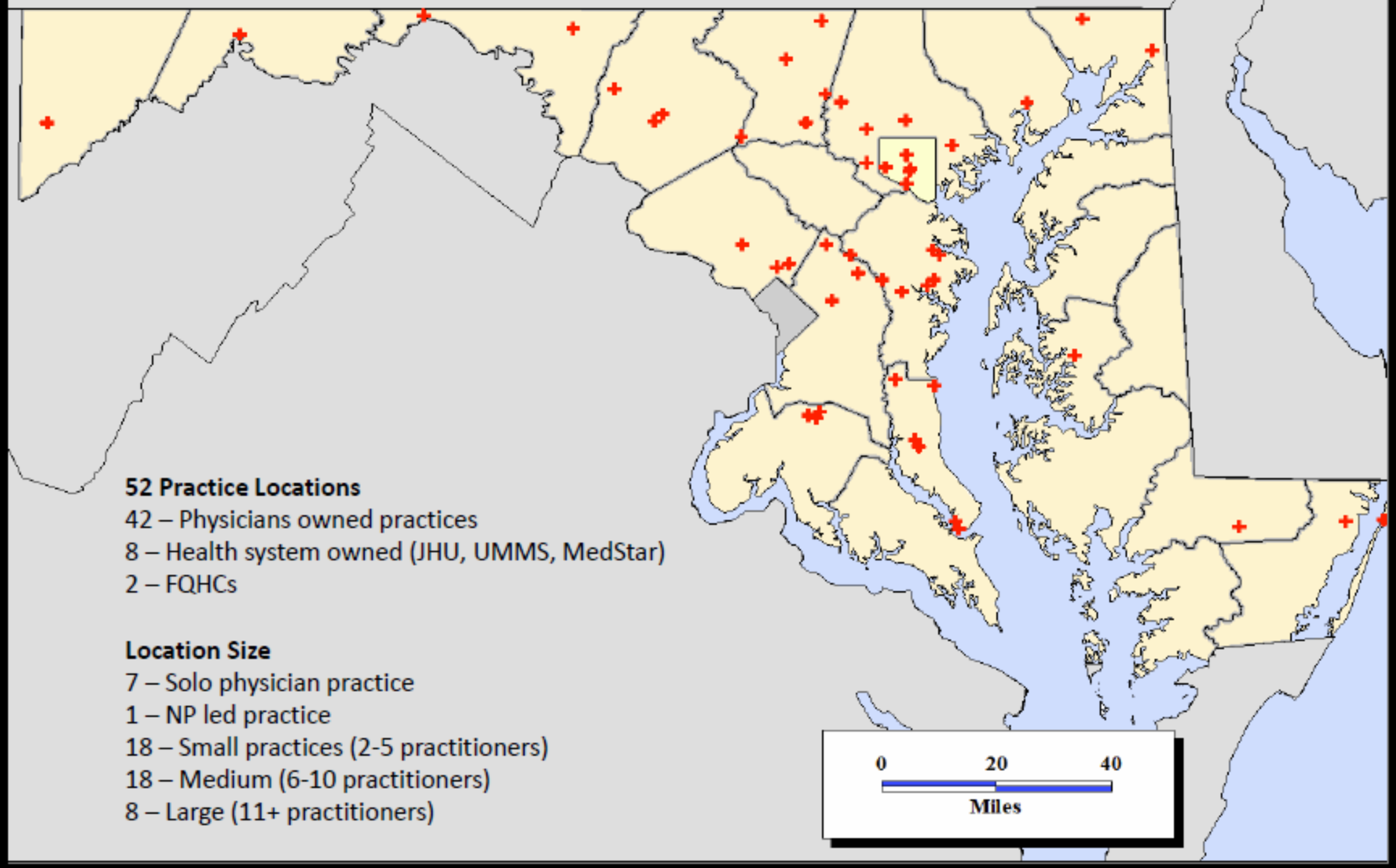
- Tools to enhance primary care are limited in Maryland law
- Higher payment for primary care alone would be inadequate

Legislation in 2010 established

- Authority of the state to launch a Multi-Payer PCMH pilot
- Exemption for a cost-based incentive payment tied to PCMH
- Authority for carriers to establish single carrier PCMH programs with incentive-based reward structure (shared savings) and data sharing

Slide courtesy MHCC

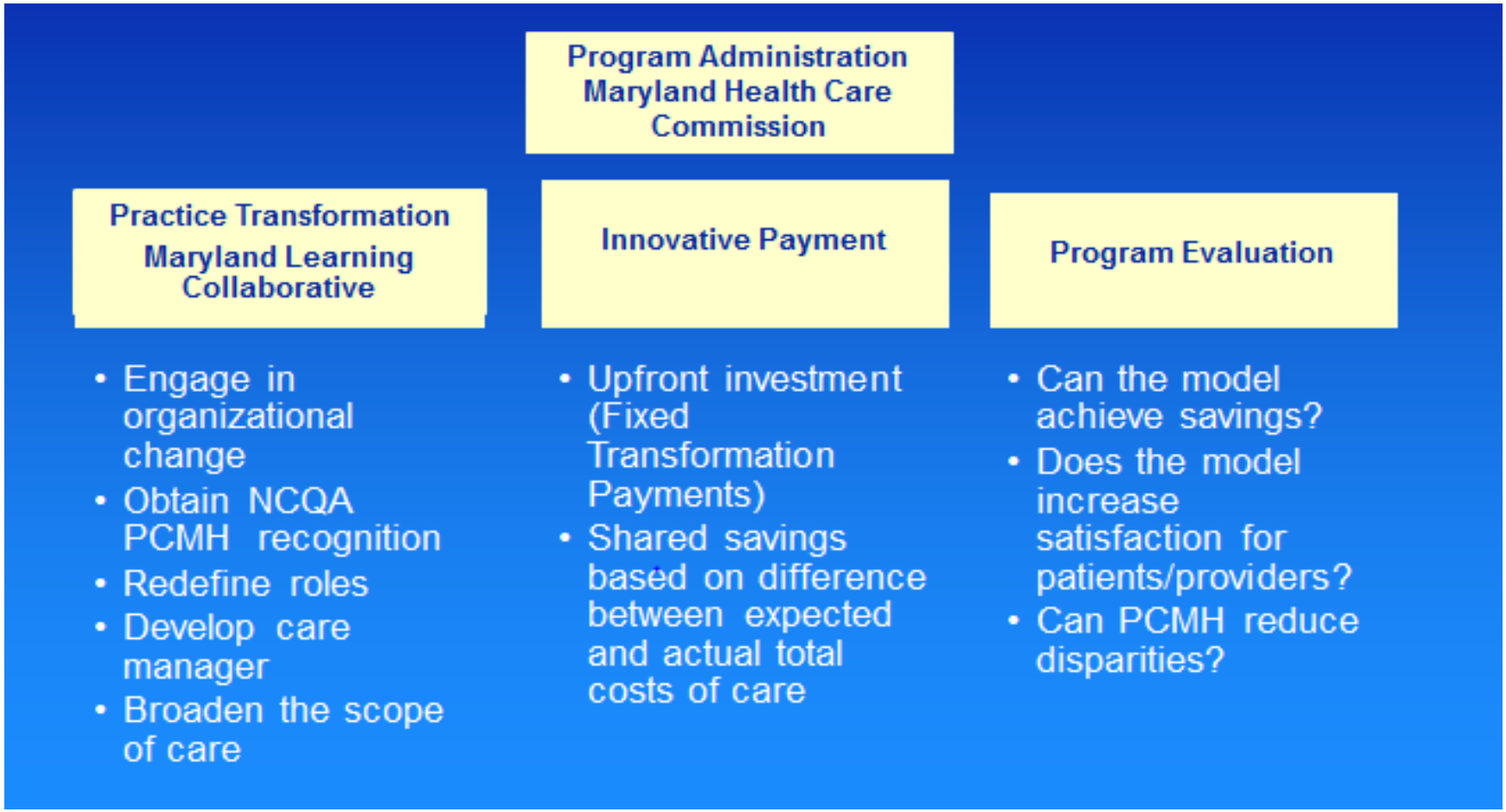
MMPP Practice Sites



52 Practice Locations
42 – Physicians owned practices
8 – Health system owned (JHU, UMMS, MedStar)
2 – FQHCs

Location Size
7 – Solo physician practice
1 – NP led practice
18 – Small practices (2-5 practitioners)
18 – Medium (6-10 practitioners)
8 – Large (11+ practitioners)

Maryland Multi-Payer PCMH Program (MMPP)



Slide courtesy MHCC

Core Tenets of the MMPP New Model of Care

- **Greater Access**
  - Advanced access scheduling systems
  - Availability by email and phone
- **Coordination of care**
- **Teamwork and Leadership**
- **Management of information**
  - Secure patient portals
  - Working with structured data
  - Performance reporting and Quality Improvement
- **Health Information Technology optimization**

What MMPP Has Accomplished

- Reached 250,000 privately insured and Medicaid patients
- National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition achieved by 52 practices with all practices achieving Level II or III
- All practices participated in quality reporting by submitting 2011 and 2012 data: 7 of the Maryland measures are core or alternate under the Office of the National Coordinator (ONC) meaningful use; 8 of the 33 are ACO measures

Slide courtesy MHCC

Financial Incentives

Key Features : Payment Model

Fee-For-Service

Primary care practices continue to be reimbursed under their existing fee-for-service payment arrangements with health plans.

+

Fixed "Transformation" Payment

Primary care practices receive a per patient per month fee (paid semi-annually) between $3.50 and $6.00.

Practices must achieve NCQA recognition and invest a portion of their fixed payment in care coordination.

+

Incentive Payment (Shared Savings)

Primary care practices receive a share of any actual savings generated by reducing total cost of care through improved patient outcomes.

Practices must report on a set of clinical quality and utilization measures. (Performance requirements increase over 3 years.)

CMS ACO and MMPP Quality Measures Crosswalk

NQF Number	Measure Title	CMS ACO?	MMPP?
0005	CAHPS: Getting Timely Care, Appointments, and Information	X	
0005	CAHPS: How Well Your Providers Communicate	X	
0005	CAHPS: Patients' Rating of Provider	X	
0005	CAHPS: Access to Specialists	X	
0005	CAHPS: Health Promotion and Education	X	
0005	CAHPS: Shared Decision Making	X	
0006	CAHPS: Health Status/Functionl Status	X	
1789	Risk Standardized All Condition Readmission	X	
0275	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	X	
0277	Ambulatory Sensitive Conditions Admissions: Heart Failure	X	
	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	X	
0097	Medication Reconciliation	X	
0101	Falls: Screening for Future Fall Risk	X	
0041	Influenza Immunization	X	X
0043	Pneumococcal Vaccination for Patients 65 Years and Older	X	X
0421	Body Mass Index (BMI) Screening and Follow-Up	X	X
0028	Tobacco Use: Screening and Cessation Intervention	X	X
0418	Screening for Clinical Depression and Follow-Up Plan	X	
0034	Colorectal Cancer Screening	X	X
0031	Breast Cancer Screening	X	
	Screening for High Blood Pressure and Follow-Up Documented	X	
0729	Diabetes Composite: Hemboglobin A1c Control	X	
0729	Diabetes Composite: Low Density Lipoprotein Control	X	
0729	Diabetes Composite: High Blood Pressure Control	X	
0729	Diabetes Composite: Tobacco Non-Use	X	
0729	Diabetes Composite: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease	X	
0059	Diabete Mellitus: Hemboglobin A1c Poor Control	X	X
0018	Hypertension: Controlling High Blood Pressure	X	X
0075	Ischemic Vascular Disease: Complete Lipid Panel and LDL Control	X	X
0068	Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic	X	
0083	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction	X	
0074	Coronary Artery Disease Composite: Lipid Control	X	
0066	Coronary Artery Disease Composite: ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction	X	
0001	Asthma Assessment		X
0002	Appropriate Testing for Children with Pharyngitis		X
0013	Hypertension: Blood Pressure Measurement		X
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		X
0036	Use of Appropriate Medications for People with Asthma		X
0038	Childhood Immunization Status		X
0047	Asthma Pharmacologic Therapy		X
0061	Diabetes: Blood Pressure Management		X
0067	Coronary Artery Disease: Oral Antiplatelet Therapy Prescribed for Patients with CAD		X
0081	Heart Failure: ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction		X
0105	Antidepressant Medication Management		X
0575	Diabetes: HbA1c Control		X

Quality Metrics Constituting Chronic Care Domain

Domain Designation	Measure Number	Measure Name	Type of Practice
Chronic Disease	NQF Measure 1	Asthma Assessment	Adult/Pediatric
Chronic Disease	NQF Measure 13	Core: Hypertension: Blood Pressure Measurement	Adult
Chronic Disease	NQF Measure 18	Controlling High Blood Pressure	Adult
	NQF Measure 36	Use of Appropriate Medications for Asthma	Adult/Pediatric
Chronic Disease		1. Age >=4 and <=10 yrs	
Chronic Disease		2. Age >=11 and <=49 yrs	
Chronic Disease		3. Age >=4 and <=49 yrs	
Chronic Disease	NQF Measure 47	Asthma Pharmacologic Therapy	Adult/Pediatric
Chronic Disease	NQF Measure 59	Diabetes: HbA1c Poor Control (Lower is better)	Adult
Chronic Disease	NQF Measure 61	Diabetes: Blood Pressure Management	Adult
Chronic Disease	NQF Measure 67	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Adult
	NQF Measure 75	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Adult
Chronic Disease		1. LDL test present	
Chronic Disease		2. LDL test present and value < 100 mg/dL	
Chronic Disease	NQF Measure 81	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Adult
Chronic Disease	NQF Measure 575	Diabetes: HbA1c Control (<8%)	Adult

Adults (n=13)	**Chronic Disease Domain**	13 quality measures
Both (n=33)	**Chronic Disease Domain**	14 quality measures
Pediatric (n=6)	**Chronic Disease Domain**	5 quality measures

Quality Metrics Constituting Preventive Care Domain

Domain Designation	Measure Number	Measure Name	Type of Practice
Preventive Care	NQF Measure 24	A. Weight Assessment and Counseling or children >=2 and <=16 years.	Pediatric
		1. BMI present	
		2. Counseling for nutrition	
		3. Counseling for physical activity	
		B. Weight Assessment and Counseling or children >=2 and <=10 years.	Pediatric
		1. BMI present	
		2. Counseling for nutrition	
		3. Counseling for physical activity	
		C. Weight Assessment and Counseling or children >=11 and <=16 years.	Pediatric
		1. BMI present	
		2. Counseling for nutrition	
		3. Counseling for physical activity	
Preventive Care	NQF Measure 0028a	Core: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment	Adult
Preventive Care	NQF Measure 0028b	Core: Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention	Adult
Preventive Care	NQF Measure 34	Colorectal Cancer Screening	Adult
Preventive Care	NQF Measure 38	Alternate Core: Childhood Immunization Status	Pediatric
		1. DTaP vaccine	
		2. IPV	
		3. MMR	
		4. HiB	
		5. Hepatitis B vaccine	
		6. VZV	
		7. Pneumococcal vaccine	
		8. Hepatitis A vaccine	
		9. Rotavirus vaccine	
		10. Influenza vaccine	
		11. Combination 1	
		12. Combination 2	
Preventive Care	NQF Measure 41	Alternate Core: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Adult
Preventive Care	NQF Measure 43	Pneumonia Vaccination Status for Older Adults	Adult
Preventive Care	NQF Measure 421	Core: Adult Weight Screening and Follow-Up	Adult
		1. Age >= 65 years	
		2. Age >= 18 years and <= 64 years	

Adults (n=13)	**Preventive Care Domain**	7 quality measures
Both (n=33)	**Preventive Care Domain**	28 quality measures
Pediatric (n=6)	**Preventive Care Domain**	21 quality measures

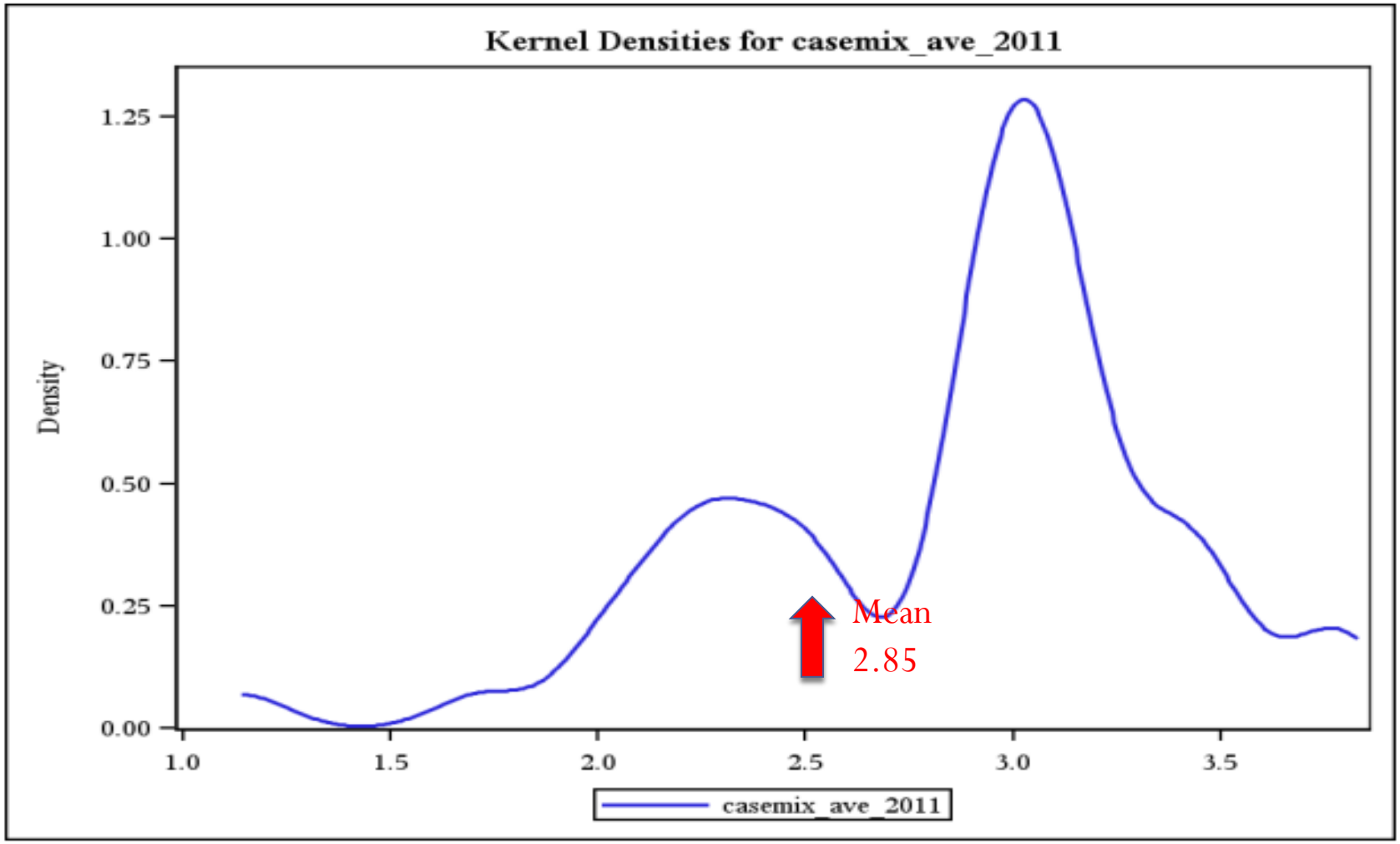
Quality Metrics Constituting Mental Care Domain

Domain Designation	Measure Number	Measure Name	Type of Practice
Mental Disease	NQF Measure 105	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment	Adult
		1. Prescribed antidepressant medications >=84 days after the FIRST diagnosis of major depression	
		2. Prescribed antidepressant medications >=180 days after the FIRST diagnosis of major depression	

A/B (N=46)	**Mental Health Domain**	2 quality measures

ACG Spread for Practices and Stratification by Low and High Case Mix

Analysis Variable : casemix_ave_2011							
N	Mean	Std Dev	Minimum	25th Pctl	Median	75th Pctl	Maximum
52	2.8521020	0.5393034	1.1393333	2.4722406	2.9614949	3.1570427	3.8287126



Data

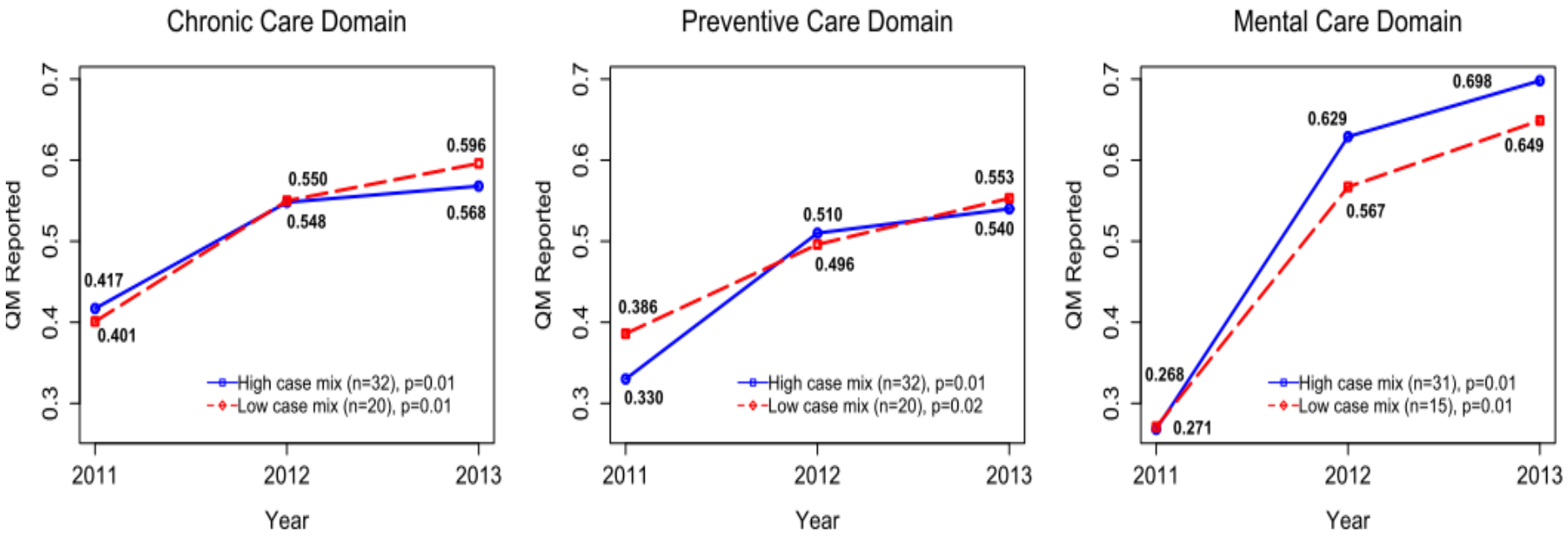
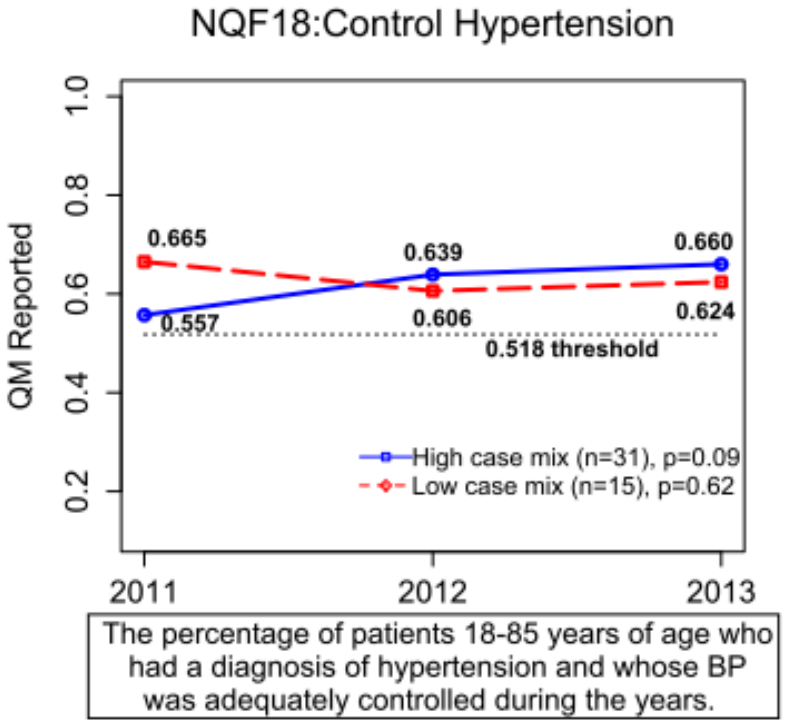
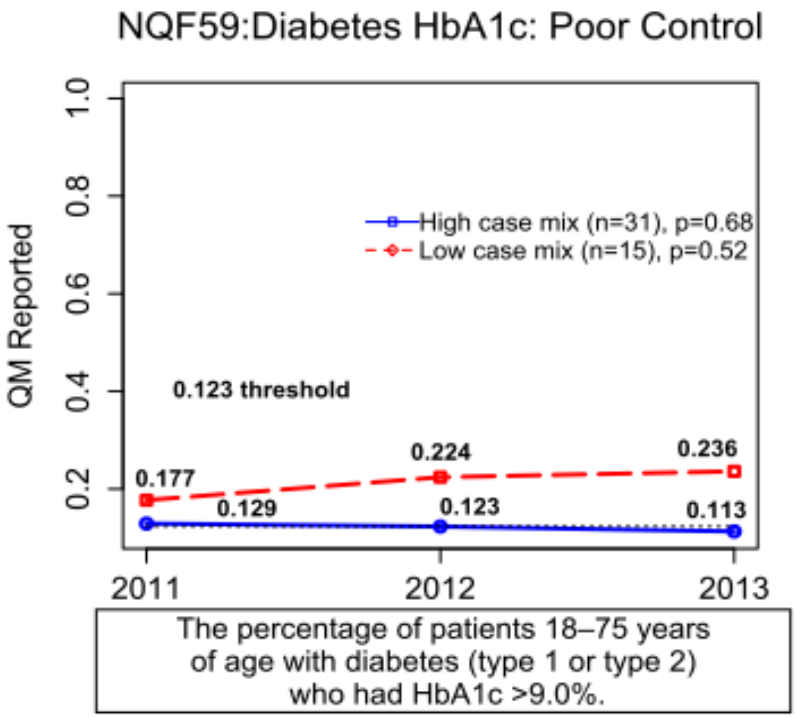


Figure 1. Average NQF quality metrics (QM) scores reported over 2011-2013, stratified by practices with high and low case mix from 2010.

P values designate statistical significance of the mean total change comparing 2011 to 2013. Total number of practices is 52 (6 pediatric, 14 adult, and 32 mixed).

NQF 18 and 59





P values designate statistical significance of the mean total change comparing 2011 to 2013. Total number of practices is 52 (6 pediatric, 14 adult, and 32 mixed).

NQF 18- A Deeper Look

Percentage of patients 18-85 Years with diagnosis of Hypertension and BP controlled <140-90

BASELINE Year 2011 (no change)

	N practices	Minimum	Median	Maximum
1. High Tier	14	0.000	0.191	0.815
2. Medium Tier	15	0.537	0.635	0.732
3. Low Tier	17	0.410	0.841	1.000

TOTAL CHANGE 2011 to 2013

	N practices	Minimum	Median	Maximum
1. High Tier	14	0.120	0.449	0.859
2. Medium Tier	15	-0.055	0.010	0.092
3. Low Tier	17	-0.415	-0.186	-0.116

NQF 59 - A Deeper Look

Percentage of patients 18-75 years with Diabetes Type 1 or 2 who had HbA1c>9.0% in 46 adult practices

BASELINE Year 2011 (no change)				
	N practices	Minimum	Median	Maximum
1. High Tier	11	0.061	0.252	0.886
2. Medium Tier	21	0.000	0.069	1.000
3. Low Tier	14	0.000	0.037	0.265
TOTAL CHANGE 2011 to 2013				
	N practices	Minimum	Median	Maximum
1. High Tier	11	-0.817	-0.121	-0.005
2. Medium Tier	21	0.000	0.015	0.046
3. Low Tier	14	0.058	0.106	0.488

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- Questions?
- Comments?